State of West Virginia

West Virginia Board of Medicine
101 Dee Drive, Suite 103
Charleston, WV 25311
Telephone (304) 558-2921
Fax (304) 558-2084

PHYSICIAN ASSISTANT APPLICATION FOR PRESCRIPTIVE WRITING PRIVILEGES

The following information must be submitted with this application:

1. $50.00 Fee – Cashiers check or money order only, payable to the WV Board of Medicine. No personal checks are accepted. This fee is non-refundable.
2. Documentation of current certification status from the National Commission on Certification of Physician Assistants.
3. The completed individual physician assistant formulary (pages 3, 4, and 5) initialed and signed on each page by your supervising physician(s) and signed by you.
4. An original transcript from your school showing completion of an approved pharmacology course. This transcript must be forwarded directly to our office from the school. If you have had prescriptive writing privileges from this Board in the past, you do not need to resubmit a copy of your transcript.
5. A sample of the prescription form you will be using. Do not have your prescription forms printed until after your sample has been approved by the Board. Additionally, if you use electronic scripts, please submit a sample of it also.

Incorrectly completed formulary sheets or samples of applicant's intended prescription form will be returned to you for correction. Approval **will not** be granted until corrections have been made to the satisfaction of the Board. You **may not** write any prescriptions until you receive written permission from this Board.

You must complete this application in its entirety, including submission of supporting documents, or it will be returned to you. This will delay your request.

Board meetings are held every other month beginning in January. Applications must be completed and received in the Board office 15 business days prior to the next regularly scheduled Board meeting. Those received after this time will be held until the following Board meeting. Temporary approval is not given for prescriptive writing privileges.

The DEA requires a physician assistant to have a DEA number separate from the supervising physician. You must contact the DEA directly to find out what you are required to do to obtain your DEA number. You may contact the DEA at www.justice.gov/dea/ or 1-800-882-9539.

INSTRUCTIONS FOR COMPLETING PRESCRIPTIVE WRITING PRIVILEGE DRUG FORMULARY

1. **The supervising physician(s) and physician assistant shall carefully review the physician assistant rule with particular attention to the rule portions regarding prescriptive privileges.**

2. No drug may be used which is not in the Board approved formulary. Drugs followed by a parenthesis, for example (5mg. – 20), indicate maximum strength and dosage units.

3. The supervising physician(s) shall select only those drugs deemed necessary for the applicant to carry out the duties delegated by the supervisor(s).

4. **The supervisor(s) shall select categories or individual medications by placing his or her initials in the space provided. Strike through all medications not permitted by the supervisor(s).**

5. The supervisor(s) and physician assistant shall sign and date at the bottom of each formulary selection page. The names should also be typed below the signatures of the supervising physician(s) and physician assistant.

6. **Prescription forms used by a physician assistant must be approved by the Board of Medicine and shall follow the format set forth in the rule and the example provided by the Board. Effective June 1, 2009, it is no longer required to have drugs imprinted on the back of the prescription form.**

7. Your Board approved formulary will be forwarded to the Board of Pharmacy. Though your approved medications are no longer required to be imprinted on the back of the prescription form, your failure to conform to your approved formulary will continue to put your license in jeopardy.

8. Prescriptions for schedules III through V should not have the DEA number of the physician assistant written or printed on the prescription. There should be a line on the prescription for writing in the DEA number.

IF THE FORMULARY IS NOT COMPLETED ACCORDING TO THESE INSTRUCTIONS, IT WILL BE RETURNED TO THE PHYSICIAN ASSISTANT, THUS DELAYING THE PROCESSING OF THIS APPLICATION.

WEST VIRGINIA BOARD OF MEDICINE
101 DEE DRIVE, SUITE 103
CHARLESTON, WV 25311
(304) 558-2921

APPLICATION FOR PRESCRIPTIVE WRITING PRIVILEGES

Name:_____ Contact Phone:_____

Mailing Address:_____

City:_____ State:_____ Zip:_____ Email: _____

Primary Work Address:_____

City:_____ State:_____ Zip:_____ Work Phone:_____

CURRENT AND/OR MOST RECENT EMPLOYMENT INFORMATION

Please list the following: all supervisors you are currently approved to work under; and each job location you have been approved to work at under each supervisor. Also indicate whether you do or do not currently have PWP under each supervisor. If more space is needed, copy this page and attach to the application.

Supervising physicians:

1. _____ Current PWP under this supervisor? Y or N

   Job Locations (with addresses and phone numbers):

   1. _____ Phone number:_____
   2. _____ Phone number:_____
   3. _____ Phone number:_____

2. _____ Current PWP under this supervisor? Y or N

   Job Locations (with addresses and phone numbers):

   1. _____ Phone number:_____
   2. _____ Phone number:_____
   3. _____ Phone number:_____

3. _____ Current PWP under this supervisor? Y or N

   Job Locations (with addresses and phone numbers):

   1. _____ Phone number:_____
   2. _____ Phone number:_____
   3. _____ Phone number:_____

REQUEST FOR PRESCRIPTIVE WRITING PRIVILEGES

Please list all supervisors and job locations at which you are requesting **new** privileges and/or **changes** to your current privileges. You will not be approved for prescriptive writing privileges for a supervisor or location that has not previously received approval as a work location from this Board. If more space is needed, copy this page and attach to the application.

Supervising physicians:

1. _____

   Job Locations (list physical address): Telephone numbers:

   1. _____ _____
      _____
   2. _____ _____
      _____
   3. _____ _____
      _____

2. _____

   Job Locations (list physical address):

   1. _____ _____
      _____
   2. _____ _____
      _____
   3. _____ _____
      _____

3. _____

   Job Locations (list physical address):

   1. _____ _____
      _____
   2. _____ _____
      _____
   3. _____ _____
      _____

Employer Name & Address: _____

_____

WEST VIRGINIA BOARD OF MEDICINE PHYSICIAN ASSISTANT FORMULARY

(The supervising physician must **initial** each approved medication and sign at the bottom of this list. **Strikethrough** all medications not permitted by supervisor.)

- The formulary shall exclude Schedules I and II of the Uniform Controlled Substances Act, antineoplastics, radio-pharmaceuticals, general anesthetics and radiographic contrast materials.
- Prescriptions written for Schedule III drugs shall be limited to a seventy two (72) hour supply and may not authorize a refill.
- Prescriptions written for Schedule IV or V drugs shall be no more than ninety (90) dosage units or a thirty (30) day supply, whichever is less, and may not authorize a refill.

ANALGESICS

_____ Nonscheduled analgesics
_____ Schedule IV and V
(Schedule III only as listed)
_____ Acetaminophen/codeine
(325mg/30mg – 24) (C III)
_____ Acetaminophen/codeine elixir
(120mg/12mg per 5 cc – 24 doses) (CIII)
_____ Acetaminophen/hydrocodone
(325mg/5mg – 24) (CIII)
_____ Aspirin/butalbital/caffeine (Fiorinal) (CIII)
(#24)
_____ Aspirin/codeine (325mg/30mg – 24) (CIII)

_____ **ANTIALZHEIMER'S AGENTS**
_____ **ANTIANAPHYLACTIC AGENTS**
_____ **ANTIARRHYTHMICS &**
CARDIOVASCULAR AGENTS
(non-injectable only)
_____ **ANTIARTHROPODS**
_____ **ANTIASTHMATIC AGENTS**
_____ **ANTIBIOTICS**
(EXCEPT chloramphenicol)
_____ **ANTICOAGULANTS**

ANTICONVULSANTS

_____ All non-scheduled agents
_____ Diazepam rectal (10mg – 2) (C IV)
_____ Phenobarbital (C IV)

_____ **ANTIDEPRESSANTS**
(except MAO Inhibitors)
_____ **ANTIDIARRHEALS**
_____ **ANTIFUNGAL AGENTS**
_____ **ANTIGOUT AGENTS**
_____ **ANTIHELMINTHS**
_____ **ANTIHISTAMINES**
_____ **ANTIHYPERTENSIVE AGENTS**
_____ **ANTIMIGRAINE AGENTS**
(excluding scheduled drugs**)**
_____ **ANTINAUSEANTS**
_____ **ANTIPARKINSON AGENTS**
_____ **ANTIPSYCHOTIC AGENTS**
(excludes clozapine)
_____ **ANTIREFLUX AGENTS**
_____ **ANTIRETROVIRAL AGENTS/**
ANTIHIV AGENTS
_____ **ANTITUSSIVES**
(no Schedule III permitted)
_____ **ANTIULCER AGENTS**
_____ **ANTIVIRAL AGENTS**

_____M.D. _____M.D. _____P.A.-C
Supervisor signature Supervisor signature Physician Assistant signature

_____ _____ _____
Print or type name Print or type name Print or type name

Date: _____ Date: _____ Date: _____

Rev. 7/12

WEST VIRGINIA BOARD OF MEDICINE PHYSICIAN ASSISTANT FORMULARY

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_____ **COMBINATIONS OF APPROVED DRUGS**
_____ **CONTRACEPTIVES: ORAL, INJECTABLE, TOPICAL**
_____ **DECONGESTANTS**
_____ **DIABETIC AGENTS AND SUPPLIES**
_____ **DIGESTANTS**
_____ **DIURETICS**
_____ **ESTROGENS AND PROGESTINS**
_____ **EXPECTORANTS AND MUCOLYTIC AGENTS (**except acetylcysteine**)**
_____ **GLUCOCORTICOID AGENTS**
_____ **HEMORRHOIDAL PREPARATIONS**
_____ **HYPOLIPIDEMIC AGENTS**
_____ **HYPOTHYROID TREATMENT AGENTS**
_____ **INFLAMMATORY BOWEL TREATMENT AGENTS**
_____ **LAXATIVES**

MISCELLANEOUS
_____ Bellergal (phenobarbital/ergotamine/belladonna alkaloids) (C IV)
_____ Durable medical equipment
_____ Oxygen
_____ Probenecid
_____ Atomoxetine HCl (Strattera)

_____ **MUSCLE RELAXANTS**
_____ **NON-NARCOTIC ANALGESICS**
_____ **NONSTEROIDAL ANTIINFLAMMATORY AGENTS**
_____ **OPHTHALMIC PREPARATIONS**
_____ **OSTEOPOROSIS AGENTS**
_____ **OTIC PREPARATIONS**
_____ **PDE-5 INHIBITORS**
_____ **PLATELET AGGREGATION INHIBITORS/BLOOD MODIFIERS**
_____ **POTASSIUM SUPPLEMENTS**
_____ **SMOKING DETERRENTS**
_____ **TOPICAL SKIN AND MUCOUS MEMBRANE AGENTS**
_____ **URINARY AGENTS**
_____ **VACCINES AND TOXOIDS**
_____ **VITAMINS, MINERALS, AND IRON PREPARATIONS**

_____M.D. _____M.D. _____P.A.-C
Supervisor signature Supervisor signature Physician Assistant signature

_____ _____ _____
Print or type name Print or type name Print or type name

Date: _____ Date: _____ Date: _____

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Front of script:

NAME OF HEALTH CARE FACILITY
PHYSICAL ADDRESS OF HEALTH CARE FACILITY
PHONE NUMBER OF HEALTH CARE FACILITY

SUPERVISOR NAME _____, P.A.-C.

NAME: _____

ADDRESS: _____ DATE: _____

_____

Rx

"Sample"

Please label
Refills 1 2 3 4 5 NR

_____, P.A.-C. _____DEA #

This prescription may be filled with a generically equivalent drug product unless the words "Brand Medically Necessary" are written in the practitioner's own handwriting, on this prescription form.